

YOUR GROUP INSURANCE PLAN BENEFITS

HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS
CLASS 0002 - INTERNS AND RESIDENTS OF CAMBRIDGE HOSPITAL
IN MASSACHUSETTS
(LONG TERM DISABILITY)

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000
www.GuardianAnytime.com

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

New Mexico Residents
Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

httsp://www.osi.stat.nm.us/ConsumerAssistance/index.aspx

CCN-2019-NM B999.0042

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

We, The Guardian, certify that the employee named below is entitled to the insurance benefits provided by The Guardian described in this certificate, provided the eligibility and effective date requirements of the plan are satisfied.

Group Policy No.	Certificate No.	Effective Date
Issued To		

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

The Guardian Life Insurance Company of America

Stuart J Shaw
Vice President, Risk Mgt. & Chief Actuary

CGP-3-R-STK-90-3 B110.0023

TABLE OF CONTENTS

GENERAL PROVISIONS
- Limitation of Authority 1
- Examination and Autopsy 1
- Accident and Health Claims Provisions 1

ELIGIBILITY FOR DISABILITY COVERAGE
- Employee Coverage 3

LONG TERM DISABILITY HIGHLIGHTS 4

LONG TERM DISABILITY INCOME INSURANCE
- Claim Provisions 6
- How This Plan Works 7
- Special Limitations 16
- Exclusions 18
- Definitions 18
- Converting Your Group Long Term Disability Income Insurance 22

CERTIFICATE AMENDMENT 24

REQUIRED DISCLOSURE STATEMENT 28

GLOSSARY 29

STATEMENT OF ERISA RIGHTS 32

GENERAL PROVISIONS

As used in this booklet:

"Covered person" means an employee insured by this *plan.*

"Employer" means the *employer* who purchased this *plan.*

"Our," "The Guardian," "us" and "we" mean The Guardian Life Insurance Company of America.

"Plan" means the Guardian *plan* of group insurance purchased by your *employer.*

"You" and "your" mean an employee insured by this *plan.*

CGP-3-R-GENPRO-90 B160.0013

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, plan or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or plan, or any requirements of The Guardian; (c) bind us by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

CGP-3-R-LOA-90 B160.0004

Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90 B160.0006

Accident and Health Claims Provisions

Your right to make a claim for any *accident and health* benefits provided by this *plan,* is governed as follows:

Notice You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number.

Proof of Loss We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 120 days of the loss.

Late Notice of Proof We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled as soon as we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

Limitations of Actions You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.

Workers' Compensation The *accident and health* benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

ELIGIBILITY FOR DISABILITY COVERAGE

B329.0002

Employee Coverage

Eligible Employees

To be eligible for coverage under this *plan,* you must meet the following conditions: (a) you must be an *active full-time resident* employed by HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS; (b) you must hold the degree of Doctor of Medicine; and (c) you must be a member of, or eligible for membership in, the American Medical Association.

"Active full-time resident" means you are performing all the duties associated with a program of *residency,* for at least the number of hours in a normal work week established by HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS for persons engaged in such a program.

CGP-3-R-EE-MR-05 B329.0195-R

When Your Coverage Starts

Employee benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be actively at work on a *full-time* basis on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you return to active *full-time* work.

Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a *full-time* basis on your last regularly scheduled work day.

CGP-3-EC-90-2.0 B264.3202

When Your Coverage Ends

Your long term disability coverage ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

It also ends on the date you stop being a member of a class of employees eligible for insurance under this *plan,* or when this *plan* ends for all *employees.* And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

Read this booklet carefully if your coverage ends. You may have the right to replace certain group benefits with converted policies.

CGP-3-EC-90-3.0 B329.0053

LONG TERM DISABILITY HIGHLIGHTS

This page provides a quick guide to some of the Long Term Disability plan features which people most often want to know about. But it's not a complete description of your Long Term Disability plan. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

CGP-3-LTD94-A-HL B350.0929

Elimination Period

For disability due to injury . . . . . 180 days.

For disability due to sickness . . . . . 180 days.

CGP-3-LTD94-B-HL B350.0939

Gross Monthly Benefit

. . . . . $3,500.00.

Note: We integrate your gross monthly benefit with certain other income you may receive. Read all of the terms of this plan to see what income we integrate with, and how.

CGP-3-LTD94-A-HL B350.0931

Maximum Payment Period

For a disability starting before the employee reaches age 60, the maximum payment period will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

For a disability starting on or after the employee reaches age 60, the maximum payment period will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years

Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

But if an employee whose disability starts after age 60 reaches the end of the maximum payment from this table before he reaches the Social Security Normal Retirement Age, we will extend his maximum payment period until he reaches Social Security Normal Retirement Age.

CGP-3-LTD94-B-HL B350.0816

LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income when it is reduced by disability. What we pay and the terms for payment are explained below. All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

Claim Provisions

Filing A Claim For Benefits

You must send us written notice of an *injury* or *sickness* for which you intend to file a long term disability claim within 30 days of the *injury* or start of the *sickness* for which a claim is being made. This notice should include your name and Social Security number and the *plan* number.

We will furnish you with claim forms for filing proof of *disability* within 15 days of our receipt of the initial notice of your intent to file a claim. The completed claim forms must be returned to us within a reasonable period of time. If we do not furnish the forms within the time stated, we will accept a written description of the *injury* or *sickness* that is the basis for the claim in place of our form. You must detail the nature and extent of the *disability* for which the claim is being made. If necessary to determine our liability, as part of proof of loss, we may require:

(a) certification of the extent and nature of your *disability* from all *doctors* who have treated you for the cause of your *disability;*

(b) certification of income from any other sources of income to which you may be entitled which may affect our benefit payments;

(c) satisfactory evidence that you have applied for all benefits and payments from other income sources to which you may be entitled; and

(d) proof of any income from other sources that you have received.

We may require you to authorize release of medical and income data by the sources of such data, including the providers of medical and/or dental services. Any information not furnished or for which the release of authorization to obtain data is not obtained can result in suspension or delay of long term disability benefit payments until such information or authorization is received by us.

Time Limit For The Filing Of A Claim

Any claim not filed within a reasonable period of time following the end of the elimination period will be denied and no long term disability benefits will be payable unless we receive written proof that you lacked the legal capacity to file the claim or that it was not reasonably possible for you to file the claim. In no event will benefits be payable for more than one year retroactively from the date the claim is filed.

Continued Proof Of Disability

Additional proof will be required. Written proof of your continued *disability* and *doctor's* care must be provided to us within 30 days of each date we make such request.

Payment Of Benefits

Benefits for the long term disability income insurance are payable once every month, provided you continue to submit periodic written proof of loss and any current earnings as required by us. We pay all long term disability benefits to you, if legally competent. If you are not legally competent, we will pay all benefits to which you are entitled to the legal representative of your estate. We have the right to pay any benefits to which you are entitled which remain unpaid at your death to one of the following: (a) your estate; or (b) your spouse, parents, children or brothers and sisters.

Examination

If you make a claim for benefits, we have the right to require that you be examined by a *doctor* as often as we feel is necessary. And we have the right to terminate or suspend your *net monthly payments* if you fail to attend such an examination. In such case, your *net monthly payments* may be resumed, provided that: (a) the required examination occurs within a reasonable period of time; and (b) you continue to be entitled to *net monthly payments* under all other provisions of this *plan.*

For other information on filing a claim, see this plan's "Accident and Health Claims Provisions."

How This Plan Works

When And How This Plan's Net Monthly Payments Start

To start getting *net monthly payments* under this *plan,* you must meet all of the following conditions:

- you must: (a) become disabled while insured by this *plan;* and (b) stay both disabled and insured by this *plan* continuously throughout the elimination period.
- you must be: (a) under a *doctor's* regular care for the cause of your *disability;* and (b) receiving appropriate medical care for the cause of your *disability* and for any other *sickness* or *injury* which exists before, or occurs during, the period you are disabled under the *plan.*
- you must send us acceptable written proof of: (a) your *disability;* (b) your *prior monthly earnings;* and (c) any *current monthly earnings.*

We reserve the right to determine when you meet the above conditions.

Failure to pass your regular occupational physical checkup does not constitute *disability* under this *plan.* We do not accept, as proof of *disability,* certification from a *doctor* who is: (a) yourself; or (b) your business associate, spouse, parent, child, brother or sister.

Once we approve your initial proofs of *disability* and *earnings* we start to make *net monthly payments.* The first *net monthly payment* is made one month after the end of the elimination period.

The Elimination Period

The elimination period is the period of time you must be continuously disabled before long term disability benefits are payable.

- For *disability* due to *injury,* the elimination period is 180 days.

- For *disability* due to *sickness,* the elimination period is 180 days.

Any days of *disability* which result from a *disability* for which this *plan* does not pay benefits will not count toward the elimination period. Any days during which you are not disabled will not count toward the elimination period.

The elimination period will be considered continuous if you return to work in your *regular occupation* for not more than 90 consecutive days during the elimination period. The elimination period will be extended by one day for each day you temporarily return to work. This interruption of the elimination period will not apply if you become eligible under any other group long term disability plan.

Continued Payment Of This Plan's Net Monthly Payments

To continue to be entitled to *net monthly payments* under this *plan,* you must continue to provide adequate proof of:

(a) your continued *disability;*

(b) continued regular *doctor's* care for the cause of the *disability;*

(c) any *current monthly earnings;* and

(d) any other income we integrate with that you are entitled to receive.

In addition, we may, at any time, require you to be examined by a *doctor* or medical professional of our choosing.

Your *net monthly payments* under this *plan* can be terminated or suspended if at any time you fail to comply with any of the above requirements.

See "Accident and Health Claims Provisions" for how often we can require continued proof of the items shown above.

How long we continue to make *net monthly payments* under this *plan* will be subject to all the terms of this *plan.*

CGP-3-LTD94-B-2.0 B350.0519

When Disability Ends

Your *disability* ends on the earliest of: (a) the date you earn or we determine you are able to earn at a rate of at least 80% of your *indexed prior monthly earnings;* or (b) the date we determine you are able to perform the major duties of your *regular occupation* or employment on a full-time basis, even if you choose not to perform such duties; or (c) after you have received 24 consecutive net monthly payments, the date we determine you are able to perform the major duties required of a Doctor of Medicine or any other medical practitioner, other than *rehabilitative work,* as allowed under this *plan* even if you choose not to perform such duties.

CGP-3-RES98-3 B350.3686-R

When This Plan's Payments End

This *plan's net monthly payments* end on the earliest of:

(a) the date your *disability* ends;

(b) the date you die;

(c) the end of the *maximum payment period;*

(d) the date you fail to give us any proof of *disability* we require;

(e) the date you refuse to allow any physical exam we require;

(f) the date you are no longer under the regular and continuing care of a *doctor;*

(g) the date benefits end in accord with any rehabilitation provision of this *plan.*

Maximum Payment Period

For a disability starting before the employee reaches age 60, the maximum payment period will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

For a disability starting on or after the employee reaches age 60, the maximum payment period will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

But if an employee whose disability starts after age 60 reaches the end of the maximum payment from this table before he reaches the Social Security Normal Retirement Age, we will extend his maximum payment period until he reaches Social Security Normal Retirement Age.

Recurring Disability

Benefits for *disability* cease when your *disability* ends, as described above. If your benefit ceased because your *disability* ended, and you become disabled again under this *plan* we will consider the later period of *disability* to be a recurring *disability* if:

(a) you return to active, full-time work right after a period of *disability* for which this *plan* has paid benefits;

(b) your *disability* recurs less than six months after the end of the period for which you were last entitled to a *net monthly payment* under this *plan;*

(c) your later *disability* is due to the same *sickness* or *injury* that caused the earlier period of *disability;*

(d) you do not become covered under any other group long term disability income plan during the period you are performing active full-time work;

(e) this *plan* does not terminate during the time that you are performing active full-time work; and

(f) you remain insured under this *plan* and the *employer* resumes premium payment for the coverage during any time you are performing active full-time work.

If we consider the *disability* to be a recurring *disability,* the *disability* will be treated as a continuation of the earlier *disability.* This means you will not be required to satisfy a new elimination period before benefits will be payable under this *plan* for the later *disability.* It also means that if, during any period of time you are receiving benefits under this *plan,* or during the period of *active work* that separates an earlier *disability* and a recurring *disability:* (a) any of the benefit provisions under this *plan* change; or (b) your *basic monthly earnings* or class change; those changes will not apply to the recurring disability. The benefits payable for the recurring *disability* will be based on the terms of the *plan* that applied to the earlier *disability.*

If the later period of *disability:*

(a) is due to an unrelated cause;

(b) begins six months or more after the end of the period for which *disability* benefits were payable under this *plan;* or

(c) begins after the date this *plan* ends;

the *disability* will not be considered recurring and will be treated like a new period of *disability.*

You must provide all proof of loss required by this *plan* for *disability* before benefits will be payable for a recurring *disability.*

Income We Integrate With

When you receive, or are entitled to receive, certain other income while this *plan* pays benefits, we integrate your *gross monthly benefit* with that other income. See "How Net Monthly Payments Are Calculated" for how this is done.

We integrate this *plan's* benefits with:

- commission or monies received, eligible to be received, or paid after *disability* benefits commence. This includes vested and nonvested renewal commissions.
- all disability benefits you receive from any compulsory benefit act or law. This includes any applicable temporary disability or state disability benefits required by state law.
- all disability benefits you are entitled to receive from any group plan sponsored by the *employer,* whether insured or self-insured. This includes payments made under a group life insurance plan because of your *disability.* This does not include payments made under a group life insurance plan's accelerated death benefit or similar provision which allows payment of that plan's proceeds because of your terminal illness.
- all disability benefits you are entitled to receive from any other group plan.
- all disability income you are entitled to receive under any other plan issued to you because of your employment by, or association with, the *employer;* or as a result of your membership in any: (a) union; (b) fraternal benefit society; (c) association; or (d) other similar organization.
- all income from a sick leave or salary continuation plan to which you are entitled. This includes lump sum or periodic payments of accumulated sick leave benefits, regardless of whether such plan is sponsored on a formal or informal basis.
- benefits from the United States Social Security Act, the Railroad Retirement Act, or any other like U.S. or Canadian plan or act, as follows:

  (a) all disability benefits that: (i) you receive; and (ii) your spouse and children receive as a result of your *disability;*

  (b) all unreduced retirement benefits that: (i) you receive; and (ii) your spouse and children receive as a result of your eligibility; and

  (c) all reduced retirement benefits paid to: (i) you; and (ii) your spouse and children as a result of your receipt of such benefits.

  This *plan* will integrate with any benefits shown above to which your spouse or children are entitled on account of your *disability* regardless of: (a) your marital status; (b) your place of residence; (c) your spouse's place of residence; (d) your child(ren)'s place of residence; or (e) any custody arrangements made on behalf of your children.
- all *retirement plan retirement benefits* funded by the *employer's* deposits for your benefit.
- all *retirement plan disability benefits* to which you are entitled.
- all *retirement benefits* or *retirement plan disability benefits* paid under any other *government plan* not otherwise shown, which you receive as a result of your *disability.*

- all disability benefits to which you are entitled under any: (a) *no-fault motor vehicle coverage;* (b) motor vehicle financial responsibility act; or (c) similar law. This does not apply if state law or regulation does not allow group disability benefits to be reduced by benefits from such coverage.
- all benefits you receive from: (a) a Workers' Compensation law; (b) an occupational disease law; or (c) any other act or law of like intent. This includes: (i) the Jones' Act; (ii) the Longshoreman's and Harbor Workers' Compensation Act; or (iii) any Maritime doctrine of Maintenance, Wages or Cure.

Lump Sum Payments Of Income We Integrate With

If any of the benefits described above are paid in a lump sum, we will integrate this *plan's gross monthly benefit* by the equivalent monthly rate stated in the award. If no equivalent monthly rate is specified, then the lump sum will be equally prorated over the lesser of: (a) 60 months; or (b) your *maximum payment period.*

CGP-3-LTD94-B-5.0-NY B350.1498

Application For Other Income Required

You must apply for any disability or retirement benefits we integrate with, which we feel, you may be entitled to receive. If such benefits are denied we require you to apply for them again. You are required to continue to appeal all denials until: (a) you receive written notification from the Guardian that no further appeals are necessary; or (b) all possible appeals have been exhausted.

If we feel that you are entitled to any of the benefits shown above, we will: (a) assume you are receiving such benefits; and (b) integrate the *gross monthly benefit* with the estimated amount of such benefits payable to you and any applicable dependents on behalf of your *disability.* But we do not do this if you sign our agreement concerning benefits under which you promise: (a) to apply for any benefits we integrate with; and (b) at our request, to reapply for such benefits or appeal any denial of such benefits until no further appeals can be made; and (c) repay any overpayment due to an award of such benefits. This paragraph does not apply to: (i) disability benefits from any compulsory benefit act or law; (ii) retirement benefits or retirement plan disability benefits under any other government plan which you receive as a result of your disability; and (iii) benefits from a Workers' Compensation law, an occupational disease law, or any other act or law of like intent.

If we do estimate them, we adjust your *net monthly payments* when we receive written proof: (a) of the amount awarded; or (b) that such benefits are denied after any reapplications or appeals we require. In the case of (b), if such adjustment shows we underpaid you, we pay you the full amount of the underpayment in a lump sum.

CGP-3-LTD94-B-6.0-NY B350.0788

How Net Monthly Payments Are Calculated

Your *net monthly payment* under this *plan* is based on the plan of benefits that applied to you on the date your *disability* began. For the duration of your *disability,* including recurring *disabilities* as defined by this *plan,* your *gross monthly benefit, net monthly benefit,* or *net monthly payment* will not be affected by changes in the plan of benefits for your classification. However, your *net monthly payment* will be adjusted when your *current monthly earnings* change.

When we compute your *net monthly payments,* we first calculate your *gross monthly benefit* and *net monthly benefit.*

Computing Your Gross Monthly Benefit From This Plan

Your *gross monthly benefit* is $3,500.00.

The amount of your *prior monthly earnings* used in computing your *gross monthly benefit* may be less than your actual *prior monthly earnings* right before the start of your *disability.* This will happen if:

(a) you have not submitted any proof of insurability required by this *plan;*

(b) you have submitted proof of insurability as required by this *plan,* but have not received a written approval of the proof from us;

(c) this *plan* has a maximum *gross monthly benefit* which does not allow the full amount of your *prior monthly earnings* to be used in the benefit calculation; or

(d) this *plan's* definition of *basic monthly earnings* specifies that your *earnings* are only updated once a year. When this happens, your *gross monthly benefit* will be based on the amount of your *basic monthly earnings* reported to us by the *employer* on the last scheduled reporting date.

Computing Your Net Monthly Benefit From This Plan

Your *net monthly benefit* under this *plan* is your *gross monthly benefit,* as determined on your initial date of *disability,* integrated with any other income with which this *plan* integrates that you receive or are entitled to receive. To compute your *net monthly benefit* under this *plan:*

(a) determine your *gross monthly benefit* as shown above; and

(b) from the *gross monthly benefit,* subtract the sum of all of the income with which we integrate that you receive or are entitled to receive.

The result is your *net monthly benefit.*

CGP-3-LTD94-B-7.0-NY B350.1576

Computing Your Net Monthly Payment From This Plan

Your *net monthly payment* under this *plan* is your *net monthly benefit* determined above, reduced by 50% of any *current monthly earnings* you earn while disabled.

CGP-3-LTD94-C-8.0 B350.0556

If, during any month for which this *plan* pays benefits, the sum of the following:

(a) your *net monthly payment,* as figured above;

(b) the total amount of all other income with which this *plan* integrates that you receive or are entitled to receive; and

(c) the amount of your *current monthly earnings;*

is greater than the amount of your *indexed prior monthly earnings,* your *net monthly payment* for that month will be further reduced by that portion in excess of 100% of your *indexed prior monthly earnings.* This will not apply during any period of time that you are a participant in a Guardian rehabilitation program, as described in this *plan,* and have signed a valid *rehabilitation agreement* with us.

CGP-3-LTD94-B-9.0-NY B350.0791

Cost Of Living Freeze

After we compute the first *net monthly benefit,* we do not reduce your benefit due to cost of living increases in social security benefits or other income benefits with which we integrate. We do adjust *net monthly payments* if: (a) your *current monthly earnings* change; or (b) your social security benefits or other income benefits with which we integrate change due to a recalculation of the benefit when updated information is received after the initial benefit is calculated.

Minimum Net Monthly Payment

This *plan's* minimum *net monthly payment* is $100.00.

Payments For Partial Months

When *disability* lasts part of a month, we pay 1/30 of the *net monthly payment* for each day for which we are liable. In no event will benefits be paid for any more than 30 days for any one month.

Waiver Of Premium

We waive all premiums for your long term disability income insurance which fall due while you are entitled to receive a *net monthly payment* from this *plan.*

If This Plan Ends

This insurance ends when the group *plan* ends. It also ends when this insurance is dropped from the group *plan* for all employees, or for your class. If either happens while you are disabled, we pay you benefits as if your insurance did not end. But what we pay will be based on all of the terms of this *plan.*

Overpayments - Our Recovery Rights

If we determine that we overpaid you, you must reimburse us in full. In addition, we have the right to stop paying benefits until the overpayment is satisfied. We have the right to recover overpayments made for any reason, including those that result from lump sum awards by any of the income benefits we integrate with.

CGP-3-LTD94-B-10.0-NY B350.1653

The Indexing Benefit

If you return to work while disabled, an indexing benefit is applied to your *prior monthly earnings* as described below. This benefit increases the amount of *current monthly earnings* you may earn while disabled. The indexing benefit does not increase your *gross monthly benefit, net monthly benefit* or *net monthly payment.*

You are eligible for this *plan's* indexing benefit after: (a) this *plan's* elimination period; (b) you have received 12 consecutive *net monthly payments* from this *plan;* and (c) you have returned to work.

When you first become eligible for this *plan's* indexing benefit, we multiply your *prior monthly earnings* by the indexing factor to obtain your *indexed prior monthly earnings.*

For each later year for which you are eligible for this *plan's* indexing benefit, your *indexed prior monthly earnings* will be determined by multiplying your *indexed prior monthly earnings* for the previous year by the current indexing factor.

The indexing factor is the lesser of: (a) 10%; or (b) one half the percentage change in the *CPI-W* for the prior calendar year of coverage.

While you are eligible for this indexing benefit, we calculate a new indexing factor once a year.

CGP-3-LTD94-IXB B350.0701

Rehabilitation Benefits Under This Plan

If you are disabled under this *plan* and meet selection criteria as established by the Guardian, you may be selected to enter into a *rehabilitation agreement* with us. This agreement starts when: (a) we inform you in writing that you have been accepted into the rehabilitation program; and (b) you agree in writing to participate in the rehabilitation program. You may be chosen for this program anytime you are disabled according to the terms of this *plan.* This includes during this *plan's* elimination period.

The exact terms of the *rehabilitation agreement* may be different for each employee, but all agreements will set forth a plan designed to return you to gainful employment. Gainful employment is employment that is appropriate to your disability, skills, experience and *prior monthly earnings.*

If you are chosen for a *rehabilitation agreement,* you will be entitled to an enhanced benefit based on 110% of the *net monthly payment* to which you would have been entitled had you not entered into the *rehabilitation agreement.* If you are chosen for such an agreement with us, you will continue to be subject to all the terms of this *plan.*

The enhanced benefit will start on the later of:

(a) the effective date shown on the *rehabilitation agreement;* or

(b) the date you complete the elimination period.

Your eligibility for the enhanced benefit will extend until the earliest of:

(a) the date you are no longer disabled under this *plan;*

(b) the date you earn or are able to earn at a rate of at least 80% of your *indexed prior monthly earnings;*

(c) the date you die;

(d) the end of this *plan's maximum payment period;*

(e) the date you violate any of the terms of the *rehabilitation agreement;*

(f) the date you elect to end the rehabilitation program; or

(g) the date the *rehabilitation agreement* expires.

If you end a *rehabilitation agreement* on a basis that is not agreeable to the Guardian, you may be required to repay any benefits paid that are in excess of what this *plan* would have paid had you not participated in the *rehabilitation agreement.*

There are additional advantages available to an employee who participates in a *rehabilitation agreement* as described above. For more information on these incentives and how you may become eligible to receive them, contact the Guardian *rehabilitation specialist.*

CGP-3-LTD94-RHB-NY B350.0761

Special Limitations

Mental Or Emotional Conditions, Alcohol Abuse And Drug Abuse

If you are disabled, as defined by this *plan,* by a mental or emotional condition, alcohol abuse or drug abuse, we limit this *plan's* benefits. For the long term disability income coverage of this *plan,* a mental or emotional condition will include, but is not limited to, any of the following:

- bipolar affective disorder (manic depressive syndrome).
- schizophrenia.
- delusional (paranoid) disorders.
- psychotic disorders.
- depressive disorders.
- anxiety disorders.
- somatoform disorders (psychosomatic illness).
- eating disorders.
- mental illness.

For each *disability* due to a mental or emotional condition, alcohol or drug abuse, our payments stop at the earliest of: (a) the date during any one period of *disability* that you have received 60 net monthly payments; (b) the end of the *maximum payment period;* or (c) the date *disability* ends.

Also, payments will be limited to a total of 60 months in your lifetime for all *disabilities* contributed to, or caused by, any and all of the conditions shown above.

But, if at the end of benefit payments, you are being treated for the cause of your *disability* as an inpatient in a qualified institution for at least 14 consecutive days, we extend our payments. We extend them until the earliest of: (a) 90 days from the date of your discharge; (b) the end of the *maximum payment period;* or (c) the date *disability* ends.

By "qualified institution," we mean a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your *disability.*

CGP-3-LTD94-B-11.0-NY B350.0605-R

Pre-Existing Conditions

A pre-existing condition is a *sickness* or *injury,* including all related conditions and complications, for which, in the three months before your insurance under this *plan* starts, you: (a) receive advice or treatment from a *doctor;* take prescribed drugs; or receive other medical care or treatment, including consultation with a *doctor;* or (b) exhibit symptoms which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.

A pregnancy which exists on the date your insurance under this *plan* starts is also a pre-existing condition.

We do not cover *disability* caused by such a condition until the later of: (i) the day following the date you are insured under this *plan* for at least 12 consecutive months; and (ii) the date benefit payments would otherwise start in the absence of this provision.

We do not cover any *disability* which begins before your insurance under this *plan* starts.

CGP-3-LTD94-B-12.0-NY B350.1345

If This Plan Replaces Another Plan

The pre-existing condition limitation shown above will not apply if you: (a) were insured on the day before this *plan* started under a long term disability plan the *employer* had with another insurer; and (b) meet the requirements shown below. But, this *plan* must start right after the old plan ends.

The pre-existing condition limitation will be waived if you: (a) are actively working on a full-time basis on the effective date of this *plan;* and (b) have fulfilled the requirements of any pre-existing condition exclusion or limitation of the old plan.

If you: (a) are actively working on a full-time basis on the effective date of this *plan;* but (b) have not fulfilled the requirements of any pre-existing condition limitation or exclusion of the old plan; then we will apply any period of time credited toward the satisfaction of the pre-existing condition limitation or exclusion under the old plan toward satisfaction of this *plan's* pre-existing condition limitation.

We will deduct all payments made by the old plan under an extension provision. Any benefits for a *disability* caused by a pre-existing condition that we agree to pay will be subject to all other terms of this *plan.*

This provision does not affect your rights as described in the "Credit for Prior Coverage" provision below.

CGP-3-LTD94-B-13.1-NY B350.1347

Credit For Prior Coverage

If you are a new employee, you may have been covered under a previous group or blanket disability insurance plan or policy, or employer-provided disability arrangement, that was substantially similar to this *plan,* prior to your enrollment in this *plan.* When this happens, we give credit for the time you were covered under the previous plan. To determine if a condition is pre-existing, we go back to the date your coverage under the previous plan started. But your active full-time service with the *employer* must start within 60 days of the date your coverage under the previous plan ended. And, you must enroll in this *plan* within 31 days of the date you first become eligible under this *plan.* If the employer has included an eligibility waiting period in the plan, you must still meet it before becoming insured under this *plan.*

CGP-3-LTD94-B-14.0-NY B350.1348

Exclusions

- We do not cover any period of *disability* caused, directly or indirectly, by: (a) declared or undeclared war or act of war or armed aggression; (b) your service in the armed forces, National Guard, or military reserves of any state or country; (c) your taking part in a riot or other civil disorder; (d) your commission of, or attempt to commit, a felony; (e) your being engaged in an unlawful occupation; or (f) intentional self injury or attempted suicide.
- We do not pay benefits for any period during which you are not under the regular care or treatment of a *doctor.*
- We do not pay benefits for any period of *disability* which starts before you are insured by this *plan.*

In addition, no benefits will be payable for any period during which your loss of *earnings* is not solely due to your *disability.*

CGP-3-LTD94-B-15.0-NY B350.1670

Definitions

Active Work

For The Long Term Disability Income Insurance **"active work"** means you are physically able to perform and are performing all of the regular duties of your work for the *employer* in the usual way and on a full-time basis, either at one of the *employer's* usual places of business or at some location to which the *employer's* business requires you to travel. Any changes in your long term disability benefits that are scheduled to occur on a date you are not actively working will not take place until the date you return to *active work.* However, if your return to *active work* is followed by a later period of disability which is considered a recurring *disability,* as described in this *plan,* changes which occur before or during that period of *active work* will not take place.

CPI-W means that part of the United States Department of Labor Consumer Price Index, which measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. The change in cost is expressed as a percentage of the cost of those goods and services in a base period. In computing the value of our indexing factor, we use the percentage that the *CPI-W* published in December of that year changes from the *CPI-W* published in December of the prior calendar year. If the Department of Labor stops publishing the *CPI-W,* we have the right to use some other similar standard.

CGP-3-LTD94-B-16.0 B350.0656

Disability means, solely due to your *sickness* or *injury:*

(1) For the first 24 months for which this *plan* pays benefits:

(a) you are completely unable to perform the major duties of your *regular occupation* on a full-time basis; and

(b) your *current monthly earnings,* if any, are less than 80% of your *indexed prior monthly earnings.*

(2) After this *plan* has paid benefits for 24 consecutive months, the definition of *disability* changes. For the duration of the *disability,* disability means:

(a) you are completely unable to perform, on a full-time basis, the major duties of a Doctor of Medicine or any other medical practitioner; and

(b) your *current monthly earnings,* if any, are less than 80% of your *indexed prior monthly earnings.*

While you are disabled, you can engage in: (i) any other occupation full or part-time; (ii) some, but not all, of the major duties of your *regular occupation* full or part-time; or (iii) all of the major duties of your *regular occupation* part-time.

This *plan* only covers *disability* that starts while you are insured by this *plan.*

You will not be considered *disabled* under this *plan* if you are not under the regular care and treatment of a *doctor.*

In no event will the loss of a professional or occupational license, in itself, constitute *disability.*

CGP-3-RES98-DEF-1 B350.3709-R

Doctor means any medical practitioner we're required by law to recognize, who: (a) is properly licensed or certified as such by the laws of the state where he or she practices; and (b) provides services that are within the lawful scope of his or her practice.

Earnings has the following meanings for this plan's long term disability income insurance:

- **"Basic monthly earnings"** are based on the amount of your *earnings* received from the *employer* as reported to us. These *earnings* are used in determining the amount of premiums due for the coverage and for projecting your *gross monthly benefit* under this *plan. Basic monthly earnings* means an *employee's* rate of monthly *earnings* on the day before *disability* begins. Bonuses, commissions, expense accounts, overtime pay and any other extra compensation are excluded. Any employee compensation based on your monthly earnings which is deposited into a cash or deferred compensation plan, or a salary reduction plan, qualified under IRC Section 401(k) is included. Any *employee* compensation based on excluded income listed above and any *employer* contributions deposited into such 401(k) is excluded. In case of weekly *earnings,* it refers to those *earnings* for a normal work week not exceeding forty hours. Such weekly *earnings* are multiplied by 4.333. Subject to any of this *plan's proof of insurability* requirements as of the date of each change in an *employee's* earnings, we use the *employee's* then current monthly *earnings* to set rates and to project the *employee's* gross monthly benefit for billing purposes. But the *employee* must be actively at work on a full-time basis on that date. If he is not, we do this on the date he returns to active full-time work.

- **"Current monthly earnings"** are the exact amount of monthly *earnings* you earn from working while disabled. Your *current monthly earnings* will include any income you earn while disabled but which is returned to your *employer,* partnership or any other similar business arrangement to cover any business or overhead expenses. Your *current monthly earnings* are used in determining your *net monthly payment.*

- **"Prior monthly earnings"** means your rate of *basic monthly earnings* as last reported to us prior to the start of your *disability.* Your *prior monthly earnings* are used in determining your *gross monthly benefit* under this *plan.*

- **"Indexed prior monthly earnings"** means your rate of *prior monthly earnings* adjusted annually by an indexing factor. Your *indexed prior monthly earnings* are used in determining the maximum amount of *current monthly earnings* you can earn under this *plan* and still receive benefits. For more information on this *plan's* indexing benefit see "The Indexing Benefit".

As part of proof of loss that we require, you must give us acceptable proof of your *earnings.* If you do not, we will not pay any benefits. Such proof must consist of: (a) copies of your U.S. Individual Tax Returns; (b) a statement from a certified public accountant; or (c) any other records we agree to accept.

Employer means HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS .

Government Plan means: (a) the United States Social Security Act; (b) the Railroad Retirement Act; (c) the Canadian Pension Plan; or (d) any other plan provided under the laws of a state, province or any other political subdivision. It also includes any public employee *retirement plan;* or any plan provided as an alternative to the above plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages or Cure.

Gross Monthly Benefit means this *plan's* monthly benefit before it is integrated with other income and *earnings.*

Injury means: (a) all bodily *injury* due to an accident that occurs, independent of all other causes, while you are insured by this *plan;* and (b) all complications thereof. *Disability* will be considered caused by an injury only if that *disability:* (a) is directly caused by the *injury;* and (b) begins within 90 days of the date of such *injury.*

Maximum Payment Period means the longest period that benefits are paid by this *plan* for continuous *disability.*

Net Monthly Benefit means this *plan's* monthly benefit after the *gross monthly benefit* is integrated with other income but before it is reduced by any *current monthly earnings.*

Net Monthly Payment means this *plan's net monthly benefit* less any reduction by *current monthly earnings.* See "How We Compute Net Monthly Payments" for details.

No-Fault Motor Vehicle Coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident.

Plan means the Guardian group long term disability income insurance *plan* the *employer* bought.

Regular Occupation means your occupation as performed in the general labor market in the national economy. When determining the duties of your *regular occupation* we use both the job description provided for you by the *employer* as well as the duties of that occupation as shown in the most recent version of the Dictionary of Occupational Titles, published by the U.S. Department of Labor.

Rehabilitation Agreement means a signed, written agreement between you and the Guardian. It outlines a program of vocational rehabilitation in which you agree to participate. The program outlined in the *rehabilitation agreement* is designed to return you to gainful work.

Rehabilitation Specialist means a designated employee or representative of the Guardian who is trained in vocational rehabilitation.

Rehabilitative Work means any program of work or job training that we approve in writing for you. The aim of such work is to restore your wage earning abilities.

Retirement Plan means a defined benefit or a defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

Retirement plan **"retirement benefits"** are lump sum or periodic payments by a *retirement plan* at normal or early retirement. Some *retirement plans* also make payments for disability (as defined by those plans) that start before normal retirement age. When such payments actuarially reduce the amount that would otherwise have been paid at normal retirement age, they are **"retirement benefits."** When such payments do not so reduce the normal retirement amount, they are **"disability benefits."**

Sickness means: (a) any illness or disease; (b) all related conditions; and (c) all complications and recurrences thereof. This plan treats pregnancy like a *sickness.*

We, Us, Our, and Guardian mean the Guardian Life Insurance Company of America.

Other terms with special meanings are defined where they are used.

Converting Your Group Long Term Disability Income Insurance

Eligibility For Conversion When your coverage under this group long term disability income *plan* ends, you may obtain a converted individual disability income policy, subject to the conditions below. You will be eligible for the converted individual disability income policy if you: (a) are not *disabled* under the terms of this *plan;* (b) have been covered under this *plan* (or a prior group disability income plan which this *plan* replaced) for at least 12 consecutive months immediately prior to the date your group coverage ends; (c) have successfully completed the residency program in which you were enrolled; and (d) apply to us in writing within 45 days after the date on which your coverage under this *plan* ends. By residency program, we mean a program of internship or residency in a medical specialty, accredited by the American Council for Graduate Medical Education.

But you will not be eligible for a converted individual disability income policy if your group long term disability coverage ends because you: (a) fail to make a required contribution; (b) change to a class not eligible under this *plan;* (c) fail to complete a program of residency; (d) retire; or (e) because coverage ends for all persons or all persons in a class under this *plan.*

You do not have to provide evidence of good health to obtain the converted individual disability income policy, but you may be subject to other underwriting criteria. You must provide details concerning other disability income insurance in force or applied for, or for which you would become eligible under another plan within 45 days after the date that this group coverage ends. The Guardian will not issue a converted individual disability income policy if such policy would result in your being overinsured by our standards.

To Obtain A Converted Individual Disability Income Policy

You must apply to us in writing and pay any required premium to obtain a converted individual disability income policy. You must do this within 45 days of the date on which your group long term disability coverage ends. If you fail to apply to us in writing and pay any required premium within 45 days of the date your group long term disability coverage ends, you are no longer eligible to obtain a converted individual disability income policy.

The Converted Individual Disability Income Policy

Your converted individual disability income policy, if issued, will be effective on the day your coverage under this group *plan* ends. The benefits, terms and conditions of the converted individual disability income policy will be those of the policy in use for such purpose in the state where you then live. These may be different from the benefits, terms and conditions of this group long term disability plan. The premium for the converted individual disability income policy will be that in effect for your age and class of risk on the date the policy is issued.

CGP-3-RES98-CONV B355.0019-R

CERTIFICATE AMENDMENT

This rider amends the pre-existing conditions limitation in this plan's long term disability income insurance so that the following is added:

In no event will this plan's pre-existing condition limitation result in the exclusion of coverage for a disability caused by a pre-existing condition for a period in excess of 12 months following the effective date of an employee's insurance under this plan.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-PREX-NY-08 B360.0132

CERTIFICATE AMENDMENT

This rider amends this Plan to provide additional services as described below.

ADDITIONAL SERVICES

Guardian has arranged to make available selected services for eligible Guardian policyholders and/or covered persons to receive certain services from third party vendors in addition to the insurance coverage. The policyholders pay a premium of $0.215 to Guardian to provide these services listed below for their covered persons.

The services identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian receives no fee from the respective vendors to make available the selected services. Further, Guardian will not be liable for the negligent provision of services by third party vendors.

Policyholders and covered persons will be instructed to obtain information regarding available services by logging onto www.GuardianAnytime.com or a Guardian supported website provided to the Policyholders and covered persons.

Policyholders and covered persons will be provided with complete details about available services and a telephone number to call with questions about the service.

The policyholder and covered persons will be provided the following service(s):

CGP-3-A-VAP-18-NY-H B531.0642

- **Comprehensive Employee Assistance (EAP) Services:** These services are available for each covered person. The intent of these services is to help with problems of daily living, whether professional or personal. Examples include, but are not limited to:
  - Help with child care issues,
  - Personal issues,
  - Elderly parent issues, and
  - Stress in the workplace.

  Services can be for everyday issues, or those related to a crisis. Services may be accessed 24 hours a day, 7 days a week though a website, or a 1-800 telephone number. Information about the program, including how to access it and the services it provides, can be obtained from the Policyholder.

Services are provided by Integrated Behavioral Health, Inc. (IBH). All services and products are provided solely by IBH and its contractors which are unaffiliated to Guardian. Guardian is not responsible for care or advice given by any provider or resource provided under this program. There is no additional charge above the premium to the covered person for these services. The IBH website is www.ibhworklife.com.

When this plan ends, access to the services ends for the policyholder and for all persons covered under the plan. When a policyholder no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the policyholder and for all persons covered under the plan.

When a covered person's coverage under this plan ends, access to the service ends for that person. When a covered person no longer meets the conditions for eligibility for insurance coverage access to that service ends for the covered person.

Guardian reserves the right to terminate, modify or replace any program at any time.

The Guardian Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

B531.0640

CGP-3-A-VAP-18-NY-H

CERTIFICATE AMENDMENT

This plan is amended so that if a covered person is injured because of a third party's wrongful act or negligence:

- we will pay medical, dental or loss of earnings benefits for the injury, to the extent otherwise covered by this plan, if the covered person: (a) agrees in writing to The Guardian being subrogated to any recovery or right of recovery the covered person has against that third party; (b) does not take any action which would prejudice our subrogation rights; and (c) cooperates in doing what is reasonably necessary to assist us in any recovery;
- we will be subrogated only to the extent of benefits paid by this plan because of that injury; and
- we will be subrogated only when the amounts (or portion) received by the covered person through a third party settlement or satisfied judgment is specifically identified as amounts paid as benefits under this plan.

As used in this rider:

"Subrogation" means our right to recover any benefit payments made under this plan:

- because of an injury to a covered person caused by a third party's wrongful act or negligence; and
- which the covered person later recovers from the third party or the third party's insurer.

"Third Party" means any person or organization other than The Guardian, the employer or the covered person.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-3-SUBR-NY-92 B600.0004

REQUIRED DISCLOSURE STATEMENT

For Group Plan No.: G -00348692-HN

The schedule of insurance on page CGP-3-SI of the certificate booklet is a short summary of the health insurance benefits this plan provides. These benefits, including any exclusions and limitations, are fully explained in other parts of the certificate booklet. READ THE CERTIFICATE BOOKLET WITH CARE.

As evidenced by your certificate booklet, this plan provides the following health insurance benefits:

B610.0001

Long Term Disability Income Insurance (defined as Disability Income Insurance by the New York State Insurance Department).

B610.0004

This plan does not provide Basic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department.

B610.0016

Notice The above statements are not part of the group policy. The group policy alone determines the rights and duties of: (a) the employer to whom this plan is issued; (b) the policyholder (if other than such employer); (c) the Guardian; and (d) any person covered by this plan.

B610.0017

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

Employee means a person who works for the *employer* at the *employer's* place of business, and whose income is reported for tax purposes using a W-2 form.

CGP-3-GLOSS-90 B750.0006

Employer means HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS .

CGP-3-GLOSS-90 B900.0051

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 20 hours per week), at his *employer's* place of business.

CGP-3-GLOSS.1 B750.0230

Plan means the *Guardian* group *plan* purchased by your *employer,* except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

CGP-3-GLOSS-90 B900.0039

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90 B900.0010

The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group Short Term and/or Long Term Disability Income benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Disability Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

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Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;

- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, and;
- In the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

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